

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/01/2014
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00146881 completed on 4/9/2014.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaints IN00148924 and IN00148977 completed on 5/20/2014.</p> <p>Complaint IN00146881 - Corrected.</p> <p>Survey dates: June 30 and July 1, 2014</p> <p>Facility number: 012523 Provider number: 155789 AIM number: 201027870</p> <p>Survey team: Jennifer Carr, RN - TC Angela Halcomb, RN (July 1, 2014)</p> <p>Census bed type: SNF/NF: 43 Residential: 44 Total: 87</p> <p>Census payor type: Medicare: 20 Medicaid: 23 Other: 44 Total: 87</p> <p>Sample: 3 Residential Sample: 3</p> <p>Ridgewood Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the PSR to the</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/01/2014
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Investigation of Complaint IN00146881. Quality Review completed on July 8, 2014, by Brenda Meredith, R.N.	{F 000}			